I

104TH CONGRESS
1ST SESSION

H. R. 2411

To provide assistance for the establishment of community rural health networks in chronically underserved areas, to provide incentives for providers of health care services to furnish services in such areas, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 27, 1995

Mr. ROBERTS (for himself, Mr. STENHOLM, Mr. GUNDERSON, and Mr. POSHARD) introduced the following bill; which was referred to the Committee on Commerce, and in addition to the Committees on Ways and Means and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To provide assistance for the establishment of community rural health networks in chronically underserved areas, to provide incentives for providers of health care services to furnish services in such areas, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Rural Health Development Act''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—GRANTS TO ENCOURAGE ESTABLISHMENT OF COMMUNITY RURAL HEALTH NETWORKS

SEC. 101. ASSISTANCE FOR DEVELOPMENT OF ACCESS PLANS FOR CHRONICALLY UNDERSERVED AREAS.

(a) AVAILABILITY OF FINANCIAL ASSISTANCE TO IMPLEMENT ACTION PLANS TO INCREASE ACCESS.—

(1) IN GENERAL.—The Secretary shall provide grants (in amounts determined in accordance with paragraph (3)) over a 3-year period to an eligible State for the development of plans to increase access to health care services during such period for residents of areas in the State that are designated as chronically underserved areas in accordance with subsection (b).

(2) ELIGIBILITY REQUIREMENTS.—A State is eligible to receive grants under this section if the State submits to the Secretary (at such time and in such form as the Secretary may require) assurances that the State has developed (or is in the process of

developing) a plan to increase the access of residents of a chronically underserved area to health care services that meets the requirements of subsection (c), together with such other information and assurances as the Secretary may require.

(3) AMOUNT OF ASSISTANCE.—

(A) IN GENERAL.—Subject to subparagraph (B), the amount of assistance provided to a State under this subsection with respect to any plan during a 3-year period shall be equal to—

(i) for the first year of the period, an amount equal to 100 percent of the amounts expended by the State during the year to implement the plan described in paragraph (1) (as reported to the Secretary in accordance with such requirements as the Secretary may impose);

(ii) for the second year of the period, an amount equal to 50 percent of the amounts expended by the State during the year to implement the plan; and

(iii) for the third year of the period, an amount equal to 33 percent of the

amounts expended by the State during the year to implement the plan.

(B) AGGREGATE PER PLAN LIMIT.—The amount of assistance provided to a State under this subsection with respect to any plan may not exceed $100,000 during any year of the 3-year period for which the State receives assistance.

(b) DESIGNATION OF AREAS.—

(1) DESIGNATION BY GOVERNOR.—In accordance with the guidelines developed under paragraph (2), the Governor of a State may designate an area in the State as a chronically underserved area for purposes of this section upon the request of a local official of the area or upon the Governor's initiative.

(2) GUIDELINES FOR DESIGNATION.—

(A) DEVELOPMENT BY SECRETARY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop guidelines for the designation of areas as chronically underserved areas under this section.

(B) FACTORS CONSIDERED IN DEVELOPMENT OF GUIDELINES.—In developing guidelines under paragraph (1), the Secretary shall consider the following factors:

(i) Whether the area (or a significant portion of the area)—

(I) is designated as a health professional shortage area (under section 332(a) of the Public Health Service Act), or meets the criteria for designation as such an area; or

(II) was previously designated as such an area or previously met such criteria for an extended period prior to the designation of the area under this section (in accordance with criteria established by the Secretary).

(ii) The availability and adequacy of health care providers and facilities for residents of the area.

(iii) The extent to which the availability of assistance under other Federal and State programs has failed to alleviate the lack of access to health care services for residents of the area.

(iv) The percentage of residents of the area whose income is at or below the poverty level.

(v) The percentage of residents of the area who are age 65 or older.

(vi) The existence of cultural or geographic barriers to access to health care services in the area, including weather conditions.

(3) REVIEW BY SECRETARY.—No designation under paragraph (1) shall take effect under this section unless the Secretary—

(A) has been notified of the proposed designation; and

(B) has not, within 60 days after the date of receipt of the notice, disapproved the designation.

(4) PERIOD OF DESIGNATION.—A designation under this section shall be effective during a period specified by the Governor of not longer than 3 years. The Governor may extend the designation for additional 3-year periods, except that a State may not receive assistance under subsection (a)(3) for amounts expended during any such additional periods.

(c) REQUIREMENTS FOR STATE ACCESS PLANS.—A State plan to increase the access of residents of chronically underserved areas to health care services meets the re-

quirements of this section if the Secretary finds that the plan was developed with the participation of health care providers and facilities and residents of the area that is the subject of the plan, together with such other requirements as the Secretary may impose.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for assistance under this section $10,000,000 for each of the first 3 fiscal years beginning after the date on which the Secretary develops guidelines for the designation of areas as chronically underserved areas under subsection (b)(2).

SEC. 102. TECHNICAL ASSISTANCE GRANTS FOR NETWORKS.

(a) IN GENERAL.—The Secretary shall make funds available under this section to provide technical assistance (including information regarding eligibility for other Federal programs) and advice for entities described in subsection (b) seeking to establish or enhance a community rural health network in an underserved rural area.

(b) ENTITIES ELIGIBLE TO RECEIVE FUNDS.—The following entities are eligible to receive funds for technical assistance under this section:

(1) An entity receiving a grant under section 103.

(2) A State or unit of local government.

(3) An entity providing health care services (including health professional education services) in the area involved.

(c) USE OF FUNDS.—

(1) IN GENERAL.—Funds made available under this section may be used—

(A) for planning a community rural health network and the submission of the plan for the network to the Secretary under section 103(c) (subject to the limitation described in paragraph (2));

(B) to provide assistance in conducting community-based needs and prioritization, identifying existing regional health resources, and developing networks, utilizing existing local providers and facilities where appropriate;

(C) to provide advice on obtaining the proper balance of primary and secondary facilities for the population served by the network;

(D) to provide assistance in coordinating arrangements for tertiary care;

(E) to provide assistance in recruitment and retention of health care professionals;

(F) to provide assistance in coordinating the delivery of emergency services with the pro-

vision of other health care services in the area served by the network;

(G) to provide assistance in coordinating arrangements for mental health and substance abuse treatment services; and

(H) to provide information regarding the area or proposed network's eligibility for Federal and State assistance for health care-related activities, together with information on funds available through private sources.

(2) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in paragraph (1) may not exceed $50,000 and may not be available for a period of time exceeding 1 year.

(d) USE OF RURAL HEALTH OFFICES.—In carrying out this section with respect to entities in rural areas, the Secretary shall make funds available through the State offices of rural health or through appropriate entities designated by such offices.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 for each of fiscal years 1996 through 2000 to carry out this section. Amounts appropriated under this section shall be available until expended.

SEC. 103. DEVELOPMENT GRANTS FOR NETWORKS.

(a) IN GENERAL.—The Secretary shall provide financial assistance to eligible entities for the purpose of providing for the development and implementation of community rural health networks (as defined in section 104). In providing such assistance, the Secretary shall give priority to eligible entities that will carry out such purpose in States that have developed a plan under section 101.

(b) ELIGIBLE ENTITIES.—

(1) IN GENERAL.—An entity is eligible to receive financial assistance under this section only if the entity meets the requirements of subparagraphs (A) through (C) as follows:

(A) The entity—

(i) is based in a rural area;

(ii) is described in paragraph (2), (3), or (4) of section 102(b); or

(iii) is a hospital-affiliated primary care center (as defined in section 104).

(B) The entity is undertaking to develop and implement a community rural health network in one or more underserved rural areas (as defined in section 104) with the active participation of at least 3 health care providers or facilities in the area.

(C) The entity has consulted with the local governments of the area to be served by the network and with individuals who reside in the area.

(2) COORDINATION WITH PROVIDERS OUTSIDE OF AREA PERMITTED.—Nothing in this section shall be construed as preventing an entity that coordinates the delivery of services in an underserved rural area with an entity outside the area from qualifying for financial assistance under this section, or as preventing an entity consisting of a consortia of members located in adjoining States from qualifying for such assistance.

(3) PERMITTING ENTITIES NOT RECEIVING FUNDING FOR DEVELOPMENT OF PLAN TO RECEIVE FUNDING FOR IMPLEMENTATION.—An entity that is eligible to receive financial assistance under this section may receive assistance to carry out activities described in subsection (c)(1)(B) notwithstanding that the entity does not receive assistance to carry out activities described in subsection (c)(1)(A).

(c) USE OF FUNDS.—

(1) IN GENERAL.—Financial assistance made available to eligible entities under this section may be used only—

(A) for the development of a community health network and the submission of the plan for the network to the Secretary; and

(B) after the Secretary approves the plan for the network, for activities to implement the network, including (but not limited to)—

(i) establishing information systems, including telecommunications,

(ii) recruiting health care providers,

(iii) providing services to enable individuals to have access to health care services, including transportation and language interpretation services (including interpretation services for the hearing-impaired), and

(iv) establishing and operating a community health advisor program described in paragraph (2).

(2) COMMUNITY HEALTH ADVISOR PROGRAM.—

(A) PROGRAM DESCRIBED.—In paragraph (1), a ''community health advisor program'' is a program under which community health advisors carry out the following activities:

(i) Collaborating efforts with health care providers and related entities to facili-

tate the provision of health services and health-related social services.

(ii) Providing public education on health promotion and disease prevention and efforts to facilitate the use of available health services and health-related social services.

(iii) Providing health-related counseling.

(iv) Making referrals for available health services and health-related social services.

(v) Improving the ability of individuals to use health services and health-related social services under Federal, State, and local programs through assisting individuals in establishing eligibility under the programs.

(vi) Providing outreach services to inform the community of the availability of the services provided under the program.

(B) COMMUNITY HEALTH ADVISOR DEFINED.—In subparagraph (A), the term ''community health advisor'' means, with respect to

a community health advisor program, an individual—

(i) who has demonstrated the capacity to carry out one or more of the activities carried out under the program; and

(ii) who, for not less than one year, has been a resident of the community in which the program is to be operated.

(3) LIMITATIONS ON ACTIVITIES FUNDED.—Financial assistance made available under this section may not be used for any of the following:

(A) For a telecommunications system unless such system is coordinated with, and does not duplicate, a system existing in the area.

(B) For construction or remodeling of health care facilities.

(4) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in paragraph (1)(A) may not exceed $50,000 and may not be made available for a period of time exceeding 1 year.

(d) APPLICATION.—

(1) IN GENERAL.—No financial assistance shall be provided under this section to an entity unless

the entity has submitted to the Secretary, in a time and manner specified by the Secretary, and had approved by the Secretary an application.

(2) INFORMATION TO BE INCLUDED.—Each such application shall include—

(A) a description of the community rural health network, including service area and capacity, and

(B) a description of how the proposed network will utilize existing health care facilities in a manner that avoids unnecessary duplication.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $100,000,000 for each of fiscal years 1996 through 2000 to carry out this section. Amounts appropriated under this section shall be available until expended.

(2) ANNUAL LIMIT ON ASSISTANCE TO GRANTEE.—The amount of financial assistance provided to an entity under this section during a year may not exceed $250,000.

SEC. 104. DEFINITIONS.

(a) IN GENERAL.—

(1) COMMUNITY RURAL HEALTH NETWORK.—For purposes of this title, the term ''community

rural health network'' means a formal cooperative arrangement between participating hospitals, physicians, and other health care providers which—

(A) is located in an underserved rural area;

(B) furnishes health care services to individuals residing in the area; and

(C) is governed by a board of directors selected by participating health care providers and residents of the area.

(2) HOSPITAL-AFFILIATED PRIMARY CARE CENTER.—

(A) IN GENERAL.—For purposes of this title, the term ''hospital-affiliated primary care center'' means a distinct administrative unit of a community hospital (as defined in subparagraph (B)) meeting the following requirement:

(i) The unit is located in, or adjacent to, the hospital.

(ii) The unit delivers primary health services, as defined in paragraph (1) of section 330(b) of the Public Health Service Act to a catchment area determined by the hospital and approved by the Secretary.

(iii) The unit provides referrals to providers of supplemental health services, as defined in paragraph (2) of such section.

(iv) The services of the unit are delivered through a primary care group practice (as defined in subparagraph (C)).

(v) To the extent practicable, primary health services in the community hospital are delivered only through the unit.

(vi) Qualified personnel trained in triage are placed in the unit, the emergency room, and the outpatient department to screen and direct patients to the appropriate location for care.

(vii) Each patient of the unit has an identified member of the group practice responsible for continuous management of the patient, including emergency services and referrals of the patients for inpatient or outpatient services.

(viii) To the extent practicable, excess facilities and equipment in or owned by the community hospital are covered for use in the unit.

(ix) The unit and the hospital avoid unnecessary duplication of facilities and equipment, except that the unit may install appropriate support equipment for routine primary health services.

(x) The unit is maintained as a separate and distinct cost and revenue center for accounting purposes.

(xi) The unit is operated in accordance with all of the requirements specified for community health centers in section 330(e)(3) of the Public Health Service Act (other than subparagraph (G)).

(xii) The hospital has an advisory committee that—

(I) is composed of individuals a majority of whom are health consumers in the catchment area of the hospital; and

(II) meets at least 6 times a year to review the operations of the primary care center and develop recommendations to the governing board of the hospital about the operation of

the center and the types of services to be provided.

(xiii) The unit maintains an information program for its patients that fully discloses—

(I) the covered professional services and referral capabilities offered by the unit; and

(II) the method by which patients of the unit may resolve grievances about billing for covered professional services and the quality of such services.

(B) COMMUNITY HOSPITAL.—For purposes of this title, the term ''community hospital'' means a public general hospital, owned and operated by a State, county or local unit of government, or a private community hospital that—

(A) has less than 50 beds; and

(B) primarily serves—

(i) a medically underserved population, as defined in section 330(b)(3) of the Public Health Service Act; or

(ii) a health professional shortage area, as defined in section 332(a)(1) of such Act.

(C) PRIMARY CARE GROUP PRACTICE.—For purposes of this title, the term ''primary care group practice'' means any combination of 3 or more primary care physicians who are—

(i) organized to provide primary health services in a manner that is consistent with the needs of the population served;

(ii) located in, or adjacent to, the community hospital;

(iii) who have admitting privileges at the community hospital; and

(iv)(I) who are salaried by the hospital such that a majority of the members of the group practice is full time in the primary care center; or

(II) who are organized into a legal entity (partnership, corporation, or professional association) that has a contract approved by the Secretary with the community hospital to provide primary health services.

(b) OTHER DEFINITIONS.—For purposes of this title:

(1) The term ''rural area'' has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

(2) The term ''Secretary'' means the Secretary of Health and Human Services.

(3) The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(4) The term ''underserved rural area'' means a rural area designated—

(A) as a health professional shortage area under section 332(a) of the Public Health Service Act; or

(B) as a chronically underserved area under section 101.

TITLE II—INCENTIVES FOR HEALTH PROFESSIONALS TO PRACTICE IN RURAL AREAS

Subtitle A—National Health Service Corps Program

SEC. 201. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

''SEC. 137. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

''(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

''(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.''.

(b) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act is amended by striking ''Federal, State, or local'' and inserting ''State or local''.

(c) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 137 and inserting the following:

''Sec. 137. National Health Service Corps loan repayments.
''Sec. 138. Cross references to other Acts.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of the enactment of this Act.

SEC. 202. STUDY REGARDING DESIGNATION AS HEALTH PROFESSIONAL SHORTAGE AREA; ALLOCATION OF CORPS MEMBERS AMONG SHORTAGE AREAS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study for the purpose of determining the following:

(1) With respect to the designation of health professional shortage areas under subpart II of part D of title III of the Public Health Service Act—

(A) whether the statutory and administrative criteria for the designation of such areas should be modified to ensure that all areas with significant shortages of health professionals receive such a designation; and

(B) if so, the recommendations of the Secretary for modifications in the criteria.

(2) With respect to the assignment of members of the National Health Service Corps under such subpart—

(A) whether the statutory and administrative criteria for the assignment of Corps members should be modified in order to ensure that the members are equitably allocated among health professional shortage areas; and

(B) if so, the recommendations of the Secretary for modifications in the criteria.

(b) REPORT.—Not later than May 1, 1996, the Secretary shall complete the study required in subsection (a) and submit to the Congress a report describing the findings made in the study.

SEC. 203. OTHER PROVISIONS REGARDING NATIONAL HEALTH SERVICE CORPS.

(a) PRIORITY IN ASSIGNMENT OF CORPS MEMBERS; COMMUNITY RURAL HEALTH NETWORKS.—Section 333A(a)(1)(B) of the Public Health Service Act (42 U.S.C. 254f–1(a)(1)(B)) is amended—

(1) in clause (iii), by striking ''and'' after the semicolon at the end;

(2) in clause (iv), by adding ''and'' after the semicolon at the end; and

(3) by adding at the end the following clause:

''(v) is a participant in a community rural health network, as defined in section 104 of the Rural Health Development Act.''.

(b) ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP PROGRAM.—Section 338H(b)(2) of the Public Health Service Act (42 U.S.C. 254q(b)(2)) is amended by adding at the end the following subparagraph:

''(C) Of the amounts appropriated under paragraph (1) for fiscal year 1996 and subsequent fiscal years, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program, the total number who are being educated as nurses or are serving as nurses, respectively, is increased to 20 percent.''.

Subtitle B—Incentives Under Other Programs

SEC. 211. ADDITIONAL PAYMENTS UNDER MEDICARE FOR PHYSICIANS' SERVICES FURNISHED IN SHORTAGE AREAS.

(a) INCREASE IN AMOUNT OF ADDITIONAL PAYMENT.—Section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)) is amended by striking ''10 percent'' and inserting ''20 percent''.

(b) RESTRICTION TO PRIMARY CARE SERVICES.—Section 1833(m) of such Act (42 U.S.C. 1395l(m)) is amended by inserting after ''physicians' services'' the following: ''consisting of primary care services (as defined in section 1842(i)(4))''.

(c) EXTENSION OF PAYMENT FOR FORMER SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)) is amended by striking ''area,'' and inserting ''area (or, in the case of an area for which the designation as a health professional shortage area under such section is withdrawn, in the case of physicians' services furnished to such an individual during the 3-year period beginning on the effective date of the withdrawal of such designation),''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to physicians' services furnished in an area for which the designation as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act is withdrawn on or after January 1, 1996.

(d) REQUIRING CARRIERS TO REPORT ON SERVICES PROVIDED.—Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (I); and

(2) by inserting after subparagraph (I) the following new subparagraph:

''(J) will provide information to the Secretary not later than 30 days after the end of the contract year on the types of providers to whom the carrier made additional payments during the year for certain physicians' services pursuant to section 1833(m), together with a description of the services furnished by such providers during the year; and''.

(e) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study analyzing the effectiveness of the provision of additional payments under part B of the medicare program for physi-

cians' services provided in health professional shortage areas in recruiting and retaining physicians to provide services in such areas.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate.

(f) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) shall apply to physicians' services furnished on or after January 1, 1996.

SEC. 212. DEVELOPMENT OF MODEL STATE SCOPE OF PRACTICE LAW.

(a) IN GENERAL.—The Secretary of Health and Human Services shall develop and publish a model law that may be adopted by States to increase the access of individuals residing in underserved rural areas to health care services by expanding the services which non-physician health care professionals may provide in such areas.

(b) DEADLINE.—The Secretary shall publish the model law developed under subsection (a) not later than 1 year after the date of the enactment of this Act.

TITLE III—ASSISTANCE FOR INSTITUTIONAL PROVIDERS

Subtitle A—Hospital-Affiliated Primary Care Centers

SEC. 301. HOSPITAL-AFFILIATED PRIMARY CARE CENTERS.

Section 330 of the Public Health Service Act (42 U.S.C. 254c) is amended by adding at the end the following subsection:

''(l) Of the amounts appropriated under subsection (g)(1)(A) for a fiscal year, the Secretary shall reserve not less than 10 percent, and not more than 20 percent, for the establishment and operation of hospital-affiliated primary care centers, as defined in section 104 of the Rural Health Development Act.''.

Subtitle B—Assistance to Rural Providers Under Medicare

SEC. 311. ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and negative operating losses, and the closure of the facility would limit the access of individuals residing in the facility's service area to emergency services.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as de-

termined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility is a member of a community rural health network under section 104 of the Rural Health Development Act.

''(H) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(I) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section

1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' was deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital:

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).

''(3) The term 'inpatient rural emergency access care hospital services' means services described in paragraph (2), furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be

furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather) that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.''.

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) of such Act (42 U.S.C. 1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))''.

SEC. 312. COVERAGE OF AND PAYMENT FOR SERVICES.

(a) UNDER PART A.—

(1) COVERAGE.—Section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)) is amended by striking ''or inpatient rural primary care hospital services'' and inserting ''inpatient rural primary care hospital services, or inpatient rural emergency access care hospital services''.

(2) APPLICATION OF DEDUCTIBLE AND COINSURANCE.—(A) Sections 1813(a) and 1813(b)(3)(A) of such Act (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking ''services or inpatient rural primary care hospital services'' each place it appears and inserting ''services, inpatient rural pri-

mary care hospital services, or inpatient rural emergency access care hospital services''.

(B) Section 1813(b)(3)(B) of such Act (42 U.S.C. 1395e(b)(3)(B)) is amended by inserting '', inpatient rural emergency access care hospital services,'' after ''inpatient rural primary care hospital services''.

(3) PAYMENT BASED ON REASONABLE COSTS.—Section 1814 of such Act (42 U.S.C. 1395f) is amended by adding at the end the following new subsection:

''Payment for Inpatient Rural Emergency Access Care Hospital Services

''(m) The amount of payment under this part for inpatient rural primary care hospital services shall be equal to the reasonable cost of such services (as determined under section 1861(v)), less the amount the hospital may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such reasonable cost.''.

(4) APPLICATION OF SPELL OF ILLNESS.—Section 1861(a) of such Act (42 U.S.C. 1395x(a)) is amended—

(A) in paragraph (1), by inserting '', inpatient rural emergency access care hospital serv-

ices,'' after ''inpatient rural primary care hospital services''; and

(B) in paragraph (2), by striking ''hospital or rural primary care hospital'' and inserting ''hospital, rural primary care hospital, or rural emergency access care hospital''.

(b) UNDER PART B.—

(1) COVERAGE.—Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (I);

(B) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(2) PAYMENT BASED ON REASONABLE COSTS.—Section 1833(a)(2) of such Act (42 U.S.C. 1395l(a)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (D);

(B) by adding ''and'' at the end of subparagraph (F); and

(C) by adding at the end the following new subparagraph:

''(G) with respect to rural emergency access care hospital services, the reasonable cost of such services (as determined under section 1861(v)), less the amount the hospital may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services exceed 80 percent of such reasonable cost;''.

SEC. 313. EFFECTIVE DATE.

The amendments made by this subtitle shall apply to fiscal years beginning on or after October 1, 1995.

Subtitle C—Demonstration Projects to Encourage Primary Care and Rural-Based Graduate Medical Education

SEC. 321. STATE AND CONSORTIUM DEMONSTRATION PROJECTS.

(a) IN GENERAL.—

(1) PARTICIPATION OF STATES AND CONSORTIA.—The Secretary shall establish and conduct a demonstration project to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary

care practice under which the Secretary shall make payments in accordance with subsection (d)—

(A) to not more than 10 States for the purpose of testing and evaluating mechanisms to meet the goals described in section 322; and

(B) to not more than 10 health care training consortia for the purpose of testing and evaluating mechanisms to meet such goals.

(2) EXCLUSION OF CONSORTIA IN PARTICIPATING STATES.—A consortia may not receive payments under the demonstration project under paragraph (1)(B) if any of its members is located in a State receiving payments under the project under paragraph (1)(A).

(b) APPLICATIONS.—

(1) IN GENERAL.—Each State and consortium desiring to conduct a demonstration project under this section shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require to assure that the State or consortium will meet the goals described in section 322. In the case of an application of a State, the application shall include—

(A) information demonstrating that the State has consulted with interested parties with respect to the project, including State medical associations, State hospital associations, and medical schools located in the State;

(B) an assurance that no hospital conducting an approved medical residency training program in the State will lose more than 10 percent of such hospital's approved medical residency positions in any year as a result of the project; and

(C) an explanation of a plan for evaluating the impact of the project in the State.

(2) APPROVAL OF APPLICATIONS.—A State or consortium that submits an application under paragraph (1) may begin a demonstration project under this subsection—

(A) upon approval of such application by the Secretary; or

(B) at the end of the 60-day period beginning on the date such application is submitted, unless the Secretary denies the application during such period.

(3) NOTICE AND COMMENT.—A State or consortium shall issue a public notice on the date it

submits an application under paragraph (1) which contains a general description of the proposed demonstration project. Any interested party may comment on the proposed demonstration project to the State or consortium or the Secretary during the 30-day period beginning on the date the public notice is issued.

(c) SPECIFIC REQUIREMENTS FOR PARTICIPANTS.—

(1) REQUIREMENTS FOR STATES.—Each State participating in the demonstration project under this subtitle shall use the payments provided under subsection (d) to test and evaluate either of the following mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice:

(A) USE OF ALTERNATIVE WEIGHTING FACTORS.—

(i) IN GENERAL.—The State may make payments to hospitals in the State for direct graduate medical education costs in amounts determined under the methodology provided under section 1886(h) of the Social Security Act, except that the State shall apply weighting factors that are

different than the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(ii) USE OF PAYMENTS FOR PRIMARY CARE RESIDENTS.—In applying different weighting factors under clause (i), the State shall ensure that the amount of payment made to hospitals for costs attributable to primary care residents shall be greater than the amount that would have been paid to hospitals for costs attributable to such residents if the State had applied the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(B) PAYMENTS FOR MEDICAL EDUCATION THROUGH CONSORTIUM.—The State may make payments for graduate medical education costs through payments to a health care training consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium) that is established in the State but that is not otherwise participating in the demonstration project.

(2) REQUIREMENTS FOR CONSORTIUM.—

(A) IN GENERAL.—In the case of a consortium participating in the demonstration project under this subtitle, the Secretary shall make payments for graduate medical education costs through a health care training consortium whose members provide medical residency training (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium).

(B) USE OF PAYMENTS.—

(i) IN GENERAL.—Each consortium receiving payments under subparagraph (A) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice, and may use such funds for the operation of the consortium.

(ii) PAYMENTS TO PARTICIPATING PROGRAMS.—The consortium shall ensure that the majority of the payments received under subparagraph (A) are directed to consortium members for primary care resi-

dency programs, and shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the consortium's payment amount under the project. Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, non-ambulatory training experience.

(d) ALLOCATION OF PORTION OF MEDICARE GME PAYMENTS FOR ACTIVITIES UNDER PROJECT.—Notwithstanding any provision of title XVIII of the Social Security Act, the following rules apply with respect to each State and each health care training consortium participating in the demonstration project established under this section during a year:

(1) In the case of a State—

(A) the Secretary shall reduce the amount of each payment made to hospitals in the State during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(B) the Secretary shall pay the State an amount equal to the Secretary's estimate of the

sum of the reductions made during the year under subparagraph (A) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(2) In the case of a consortium—

(A) the Secretary shall reduce the amount of each payment made to hospitals who are members of the consortium during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(B) the Secretary shall pay the consortium an amount equal to the Secretary's estimate of the sum of the reductions made during the year under subparagraph (A) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(e) ADDITIONAL GRANT FOR PLANNING AND EVALUATION.—

(1) IN GENERAL.—The Secretary may award grants to States and consortia participating in the demonstration project under this section for the purpose of planning and evaluating such projects. A

State or consortia may conduct such planning and evaluation activities or contract with a private entity to conduct such activities. Each State and consortia desiring to receive a grant under this paragraph shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for grants under this paragraph $250,000 for fiscal year 1996, and $100,000 for each of the fiscal years 1997 through 2001.

(f) DURATION.—A demonstration project under this section shall be conducted for a period not to exceed 5 years. The Secretary may terminate a project if the Secretary determines that the State or consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary.

(g) EVALUATIONS AND REPORTS.—

(1) EVALUATIONS.—Each State or consortium participating in the demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the State or consortium's participation and such interim evaluations as the Secretary may require.

(2) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration project under this subtitle begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the State and consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(h) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project under this subtitle shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

SEC. 322. GOALS FOR PROJECTS.

The goals referred to in this section for a State or consortium participating in the demonstration project under this subtitle are as follows:

(1) The training of an equal number of physician and non-physician primary care providers.

(2) The recruiting of residents for graduate medical education training programs who received a portion of undergraduate training in a rural area.

(3) The allocation of not less than 50 percent of the training spent in a graduate medical residency

training program at sites at which acute care inpatient hospital services are not furnished.

(4) The rotation of residents in approved medical residency training programs among practices that serve residents of rural areas.

(5) The development of a plan under which, after a 5-year transition period, not less than 50 percent of the residents who begin an initial residency period in an approved medical residency training program shall be primary care residents.

SEC. 323. DEFINITIONS.

In this subtitle:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term ''approved medical residency training program'' has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term ''health care training consortium'' means a State, regional, or local entity consisting of at least one of each of the following:

(A) A hospital operating an approved medical residency training program at which residents receive training at ambulatory training sites located in rural areas.

(B) A school of medicine or osteopathic medicine.

(C) A school of allied health or a program for the training of physician assistants (as such terms are defined in section 799 of the Public Health Service Act).

(D) A school of nursing (as defined in section 853 of the Public Health Service Act).

(3) PRIMARY CARE.—The term ''primary care'' means family practice, general internal medicine, general pediatrics, and obstetrics and gynecology.

(4) RESIDENT.—The term ''resident'' has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

(5) RURAL AREA.—The term ''rural area'' has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

TITLE IV—MEDICARE PAYMENT METHODOLOGIES

SEC. 401. TELEMEDICINE SERVICES.

The Secretary of Health and Human Services shall establish a methodology for making payments under part B of the medicare program for telemedicine services furnished on an emergency basis to individuals residing in

an area designated as a health professional shortage area (under section 332(a) of the Public Health Service Act).

SEC. 402. HMO-RISK CONTRACT PROGRAM.

(a) USE OF SINGLE NATIONAL AVERAGE PER CAPITA COSTS FOR ORGANIZATIONS IN ALL GEOGRAPHIC AREAS.—

(1) IN GENERAL.—Section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)) is amended by striking ''in a geographic area served by an eligible organization or in a similar area,'' and inserting ''for all areas in the United States served by eligible organizations with contracts under this section''.

(2) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contract years beginning with 1996.

(b) BUDGET NEUTRALITY.—The Secretary shall adjust the amount of payment made to eligible organizations with a risk-sharing contract under section 1876 of the Social Security Act for 1997 and subsequent years to ensure that total payments to such organizations under such section for the year do not exceed the amount which would have been paid to such organizations during the year if the amendment made by subsection (a) had not been enacted into law.

TITLE V—HOSPITAL ANTITRUST FAIRNESS

SEC. 501. ANTITRUST EXEMPTION.

The antitrust laws shall not apply with respect to—

(1) the merger of, or the attempt to merge, 2 or more hospitals,

(2) a contract entered into solely by 2 or more hospitals to allocate hospital services, or

(3) the attempt by only 2 or more hospitals to enter into a contract to allocate hospital services,

if each of such hospitals satisfies all of the requirements of section 502 at the time such hospitals engage in the conduct described in paragraph (1), (2), or (3), as the case may be.

SEC. 502. REQUIREMENTS.

The requirements referred to in section 501 are as follows:

(1) The hospital is located outside of a city, or in a city that has less than 150,000 inhabitants, as determined in accordance with the most recent data available from the Bureau of the Census.

(2) In the most recently concluded calendar year, the hospital received more than 40 percent of its gross revenue from payments made under Federal programs.

(3) There is in effect with respect to the hospital a certificate issued by the Health Care Financing Administration specifying that such Administration has determined that Federal expenditures would be reduced, consumer costs would not increase, and access to health care services would not be reduced, if the hospital and the other hospitals that requested such certificate merge, or allocate the hospital services specified in such request, as the case may be.

SEC. 503. DEFINITION.

For purposes of this title, the term ''antitrust laws'' has the meaning given such term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies with respect to unfair methods of competition.

TITLE VI—FINANCING

SEC. 601. INCREASE IN MEDICARE PART B PREMIUM FOR INDIVIDUALS WITH HIGH INCOME.

(a) IN GENERAL.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new part:

''PART VIII—MEDICARE PART B PREMIUMS FOR HIGH-INCOME INDIVIDUALS

''Sec. 59B. Medicare part B premium tax.

"SEC. 59B. MEDICARE PART B PREMIUM TAX.

''(a) IMPOSITION OF TAX.—In the case of an individual to whom this section applies for the taxable year, there is hereby imposed (in addition to any other tax imposed by this subtitle) a tax for such taxable year equal to the aggregate of the Medicare part B premium taxes for each of the months during such year that such individual is covered by Medicare part B.

''(b) INDIVIDUALS TO WHOM SECTION APPLIES.—This section shall apply to any individual for any taxable year if—

''(1) such individual is covered under Medicare part B for any month during such year, and

''(2) the modified adjusted gross income of the taxpayer for such taxable year exceeds the threshold amount.

''(c) MEDICARE PART B PREMIUM TAX FOR MONTH.—

''(1) IN GENERAL.—The Medicare part B premium tax for any month is ⅔ the amount equal to the excess of—

''(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over determined for that calendar year under section 1839(b) of the Social Security Act, over

''(B) the total monthly premium under section 1839 of the Social Security Act (determined without regard to subsections (b) and (f) of section 1839 of such Act).

''(2) PHASEIN OF TAX.—If the modified adjusted gross income of the taxpayer for any taxable years exceeds the threshold amount by less than $25,000, the Medicare part B premium tax for any month during such taxable year shall be an amount which bears the same ratio to the amount determined under paragraph (1) (without regard to this paragraph) as such excess bears to $25,000. The preceding sentence shall not apply to any individual whose threshold amount is zero.

''(d) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

''(A) except as otherwise provided in this paragraph, $100,000,

''(B) $125,000 in the case of a joint return, and

''(C) zero in the case of a taxpayer who—

''(i) is married at the close of the taxable year but does not file a joint return for such year, and

''(ii) does not live apart from his spouse at all times during the taxable year.

''(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income—

''(A) determined without regard to sections 135, 911, 931, and 933, and

''(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

''(3) MEDICARE PART B COVERAGE.—An individual shall be treated as covered under Medicare part B for any month if a premium is paid under part B of title XVIII of the Social Security Act for the coverage of the individual under such part for the month.

''(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703.''

(b) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

''Part VIII. Medicare Part B Premiums For High-Income Individuals.''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to months after December 1995 in taxable years ending after December 31, 1995.

SEC. 602. TERMINATION OF CERTAIN GRANT PROGRAMS.

Notwithstanding any other provision of law, no funds are authorized to be appropriated to carry out the following programs for fiscal year 1996 or any subsequent fiscal year:

(A) The grant program for rural health transition under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987.

(B) The program for rural outreach grants (which program was, for fiscal year 1995, carried out by the Health Resources and Services Administration with funds made available under Public Law 103–333 for such grants).

(C) The telemedicine grant program (which program was, for fiscal year 1995, carried out by the Health Resources and Services Administration with funds made available under Public Law 103–333 for rural health research).

(D) The program under section 338J of the Public Health Service Act (relating to State offices of rural health).

(E) The programs under parts A through C of title XII of the Public Health Service Act (relating to trauma care).

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